Supreme Court, U.S.
FILED

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1999

NO.

UNITED STATES OF AMERICA, ex rel., RON WEDDINGTON,

Petitioner

vs.

SCOTT & WHITE MEMORIAL HOSPITAL; SCOTT & WHITE CLINIC; SCOTT, SHERWOOD AND BRINDLEY FOUNDATION,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTIONS FOR REVIEW

Do federal statutes and regulations prevent a hospital from billing Medicare for treatment required because of the hospital's negligence, or at least require the hospital to reveal the true cause of the treatment.

1. Whether the attorney who handled the malpractice action against the hospital for taking out the patient's only functioning kidney may be the relator in a subsequent Federal False Claims Act case against the hospital.

    a. Was a settlement hearing in the malpractice case wherein Medicare's lien was mentioned a "public disclosure of allegations or transactions" of fraud?

    b. Was the attorney, who discovered that the hospital was billing Medicare for treatment necessitated by the hospital's negligence, an "original source" under the Federal False Claims Act.

2. Whether the hospital, by requesting extra payment from Medicare, without revealing that the extended hospital stay was due to the hospital's negligence, submitted a false claim.

3. Whether the hospital, knowing it was liable because of its malpractice and knowing that Medicare should be the "secondary payer," by filing claims with Medicare anyway, should be liable under the Federal False Claims Act.

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PARTIES

All of the parties are listed in the caption of the case. To petitioner's best knowledge, there are no parent companies or subsidiaries.

CITATIONS OF OPINIONS BELOW

Neither opinion was published. The Fifth Circuit Court cause number is 99-50031. The District Court cause number is W-97-CA-208.

STATEMENT OF JURISDICTION

The Fifth Circuit opinion and judgment was filed on November 8, 1999.

This Court has jurisdiction pursuant to 28 U.S.C. 1254(1).

STATUTES

31 U.S.C. § 3730(e)(4)(A)(B)

(A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil or administrative hearing, in a Congressional, administrative, or government accounting office report, hearing, audit or investigation, or from the news media unless the action is brought by the attorney general or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge

of the information on which the allegations are based and has voluntarily provided the information to the government before filing an action under this section which is based on the information.

42 U.S.C. § 1395y

"(2) Medicare Secondary Payer

(A) In General

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that-

. . . (ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workman's compensation law or plan of the United States or a state or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

REGULATIONS

42 C.F.R. § 412.46

Medical Review Requirement; DRG Validation

(a) Physician attestation. The attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted) attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. Information must be in writing in the medical record, and, except as provided in (b) of this section, the physician must sign the statement." [Paragraph (b) deals with electronic signature.]

42 C.F.R. § 412.82

Payment for Extended Length of Stay Cases (Day Outliers)

"(a) If the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterium, the intermediary will make an additional payment on a per diem basis to the discharging hospital for those days. A special request or submission by the hospital is not necessary to initiate this payment. However, a hospital may request payment for day outliers before the medical review required in paragraph (b) of this section.

(b) The PRO must review and approve to the extent required by HCFA--

(1) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay;

(2) The validity of the diagnostic and procedural coding . . . "

STATEMENT OF THE CASE

Course of Proceedings and Disposition in the Courts Below

Plaintiff filed an action under the Federal False Claims Act, 31 U.S.C. § 3729 at seq., against the hospital, clinic, and foundation Defendants. The case was tried before the District Court on stipulated facts. The District Court in its order of December 11, 1998 dismissed the case for lack of jurisdiction over the subject matter. Appeal was taken to the United States Court of Appeals for the Fifth Circuit which affirmed the actions of the District Court without comment.

Statement of Facts

In July of 1991 a surgeon employed by the Defendants mistakenly removed Charles Hyatt's only functioning kidney. Mr. Hyatt came to the hospital for cardiovascular surgery and there had been no mention of removing a kidney. However, the surgeon decided that because one of the kidneys was not functioning due to lack of blood, it should be removed. By the time it was discovered that the good kidney had been removed, it was too late to repair the damage and Mr. Hyatt had to be placed on kidney dialysis. Mr. Hyatt remained in the hospital for approximately six months, during which time a number of procedures were performed, all related to the lack of kidney function and complications resulting therefrom, and then he died.

The hospital billed Medicare and received a total of approximately $65,000, $24,000 of which was related to the cardiovascular surgery. The remainder was for treatment required because Mr. Hyatt's only functioning kidney had been

removed.

In connection with their submission of bills to Medicare, physicians employed by the Defendants made attestations regarding the diagnoses that necessitated the extra medical care for Mr. Hyatt. None of the attestations contained any medical coding or description indicating that the reason for the extended treatment to Mr. Hyatt was due to the negligent removal of his only functioning kidney.

Petitioner/Plaintiff/Relator is an attorney who handled the malpractice claim against the Defendants. Early on, he learned that Medicare was being billed for the extra treatment. He contacted Medicare through its agent and received information as to the amount of the Medicare lien.

A settlement was reached, but because one of the heirs was a minor, a "friendly suit" was instituted in a Texas court as required by state law. After a hearing, the State District Judge approved the settlement. The Medicare lien was mentioned during the hearing and in the judgment, indicating that the Medicare lien was to be paid for out of the proceeds of the settlement. Neither the nature of the lien nor the reasons for it were ever mentioned in either the hearing or the judgment.

Petitioner Weddington later filed the current action under the False Claims Act. The United States declined intervention and Petitioner proceeded.

ARGUMENT

Was There a "Public Disclosure?"

The history of the False Claims Act has featured a

struggle by Congress and the Courts to achieve:

> "the golden mean between adequate incentives for whistle blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute on their own."

United States ex rel. Springfield Terminal Ry. Co. v. Quinn, 14 F.3rd 645, 649 (D.C. Cir. 1994). Since the 1986 amendment to the act, there has been a divergence among the Courts of Appeal. The *Springfield* Court suggested that Congress sought to prohibit *qui tam* actions only when either the allegation of fraud or the critical elements of the fraudulent transaction themselves were in the public domain. 14 F.3rd at 654. That same year, however, the Fourth Circuit in *United States ex rel. Siller v. Becton Dickenson and Company*, 21 F.3rd 1339 (4th Cir. 1994) seemed to indicate that **any** information disclosed through civil litigation and on file with the Clerk's office should be a public disclosure of allegations. 21 F.3rd at 1350.

The Fifth Circuit in *United States ex rel. Federal Recoveries Services, Inc. v. Crescent City EMS, Inc.*, 72 F.3rd 447, 450 (5th Cir. 1995) clearly leaned toward the Fourth Circuit's view in *Becton*. The District Court in this case relied upon Federal Recovery Services, Inc. and its approval of the Fourth Circuit's decision in *Becton* in holding that the disclosure of a Medicare lien in the friendly suit involving the minor plaintiff was a "public disclosure." (A-6) The Fifth Circuit affirmed his decision to dismiss on jurisdictional grounds without comment, but it must be assumed that they agreed with the District Judge's reasoning.

The Seventh Circuit has aligned itself with the D.C.

Circuit's opinion in *Springfield Terminal* in *United States v. Bank of Farmington*, 166 F.3rd 853 (7th Cir. 1999). That case dealt with whether or not matters revealed during the discovery process of litigation were a "public disclosure." The Seventh Circuit stated that:

> "Here the language of the statute itself is 'public disclosure' not 'potentially accessible to the public.' A plain and ordinary meaning of 'public' is 'open to 'general observation, sight or cognition . . . manifest, not concealed . . .'; that of 'disclosure' is 'opening up to view, revelation, discovery, exposure.'"

166 F.3rd at 860. The Court noted that the Second Circuit in *Kreindler and Kreindler v. United Technologies Corporation*, 985 F.2nd 1148 (2nd Cir. 1992) and the Third Circuit in *United States ex rel. Stinson v. Prudential Ins. Co.*, 944 F.2nd 1149 (3rd Cir. 1991) would both take the opposite view. 166 F.3rd at 859, 860.

The Sixth Circuit has recently weighed in on the side of the D.C. Circuit in *Springfield*. In *United States v. A.D. Roe Company, Inc.* 186 F.3rd 717 (6th Cir. 1999), the Court stated that:

> "Before the 1986 amendments to the FCA, the FCA precluded suits based on 'evidence or information' already in the government's possession. By changing the phrase to read 'allegations or transactions,' Congress clearly intended that the public disclosures at issue be of something more than simple information from which no one could deduce that fraud had occurred."

186 F.3rd at 724. In the *Roe* case the Sixth Circuit seemed to think that the Third Circuit would be in agreement. 186 F.3rd at 724.

The *Roe* panel was dealing with a Freedom of Information Act request. The Court stated that the issue was "whether inferences of fraud reasonably could have drawn from the information contained in those documents." 186 F.3rd at 724. Finally, the *Roe* panel stated that only when there is "substantial identity" between the *qui tam* action and the publicly disclosed matters would the jurisdictional bar apply. 186 F.3rd at 725.

In the present case, it was revealed in the friendly suit involving the minor plaintiff that the hospital's negligence was the basis of the settlement and that there was a Medicare lien in the amount of approximately $65,000. There was no mention of what the Medicare lien was based upon, whether it involved payments to Scott & White Hospital or to other providers. Thus, there was no way for an opportunistic stranger to the case to be able to determine whether or not Scott & White had falsely billed Medicare for treatment required by its own negligence. Under the identical facts of this case, it seems clear that there would be no jurisdictional bar in the D.C., Sixth or Seventh Circuits. There would be a jurisdictional bar in the Fourth Circuit and, of course, the Fifth Circuit. The Second Circuit would probably align with the Fourth and Fifth and the Third Circuit might go with D.C., Sixth and Seventh, depending upon interpretation. Clearly, the question of what is "public disclosure" is unclear and is causing a great deal of confusion throughout the circuits.

Was Plaintiff an "Original Source?"

Even if this Court determines that the Fifth and Fourth Circuits are correct in their interpretation of what "public disclosure" means, there still remains a question as to who can be an "original source" under the statute. In the present case, it was stipulated that the Plaintiff had voluntarily provided his information to the government before filing an action. The District Court, however, ruled that since the Plaintiff found out that Scott & White Hospital was continuing to bill Medicare by calling the contractor to which Scott & White submitted its bill, Plaintiff could not be a person with "independent knowledge of the information on which the allegations are based." The District Court stated "obviously, Weddington was not privy to Scott & White's preparation of the Physician Attestations to Medicare." (A-7)

The District Court's decision in the present case, which was affirmed by the Fifth Circuit, seems to indicate that only an insider to the fraudulent or false claims can be a *qui tam* plaintiff under the False Claims Act.

The Seventh Circuit clearly does not make this requirement. In *United States ex rel. Lamers v. City of Green Bay*, 168 F.3rd 1013 (7th Cir. 1999) the suit involved allegations that the City of Green Bay had made false statements to the Federal Transportation Administration about federally funded bus service. The *qui tam* plaintiff was the owner of a private bus company that had been displaced by Green Bay. He walked the streets of Green Bay observing its buses in action and based upon what he saw filed the *qui tam* action. Based upon complaints he filed with the Transportation Administration, there were a number of changes made at the instance of that agency.

In holding that Lamers was an "original source," the Seventh Circuit stated at 168 F.3rd 1017, 1018.

> "Congress has tried to strike a balance between 'encouraging people to come forward with information and . . . preventing parasitic lawsuits' . . . In our case we think it's clear that Lamers provided a service to the F.T.A. by keeping an eye on how the city's practices matched up to its statements. He may be viewed by some as a bit of a busybody with his own agenda, but he is certainly not a parasite. And to a certain degree, Congress wanted to encourage busybodies who, through independent efforts, assist the government in ferreting out fraud."

In contrast to the Seventh Circuit, the Fifth Circuit has characterized *qui tam* plaintiffs as "rogues" and "viperous vermin." *United States v. Texas Tech University*, 171 F.3rd 279, 293 (5th Cir. 1999). The Fifth Circuit's distaste for the False Claims Act was again manifested in its decision in *Riley v. St. Luke's Episcopal Hospital*, 196 F.3rd 514 (5th Cir. 1999) by declaring the statute unconstitutional.

Was the Hospital's Request for Extra Payment a False Claim?

The District Court in this case expressly made no finding as to whether or not Scott & White Hospital's bills to Medicare were fraudulent or a false claim. (A-7) Plaintiff argued to the Fifth Circuit that the importance of the question and judicial economy dictated that the Appeals Court should decide that issue if it found jurisdiction was proper. Plaintiff makes the same request to this Court.

The impact of medical negligence has been known for many years, but was recently brought to wider attention by the National Academy of Sciences, whose report stated that medical errors kill 44,000 - 98,000 people per year and called for a new federal agency to which hospitals would report errors. (New York Times. 11-30-99, p. A-1). Throughout this case, Plaintiff has contended that such a system for reporting medical errors already exists, at least for those cases where the federal government is the payor.

American Hospital Association v. Bowen, 834 F.2nd 1037 (D.C. Cir. 1987) detailed the system by which hospitals are reimbursed by Medicare. That Court determined that through various amendments during the 1980's, Congress basically provided for three things: one, that hospitals would be paid a flat rate for various procedures, two, that hospitals could be paid extra money for exceptional circumstances, (known as outlier payments) and three, that peer review organizations would make a more extensive review of the quality of care by hospitals seeking Medicare payments. 834 F.2nd at 1041, FN1.

Pursuant to these statutes, the U.S. Department of Health and Human Services promulgated regulations requiring that a physician must attest to the principal and secondary diagnoses requiring the services for which the hospital would be reimbursed and that in the case of extended stay (day outliers) the peer review organization must review and approve the validity of the diagnostic coding attested to by the physician. 42 C.F.R., § 412.46 and § 412.82.

The attestations of Scott & White physicians in the case of Charles Hyatt showed that he had suffered kidney failure, but they did not indicate why. Plaintiff contends that the physicians should have revealed the reason and that there are recognized

diagnostic codes that should have been used.

The International Classification of Diseases, 9th Revision, promulgated by the U.S. Department of Health and Human Services and whose use is required for Medicare billing, attempts to list every possible diagnosis and cause that requires medical care. The Third Edition (March 1989) states at page 930 the following:

> **"SUPPLEMENTARY CLASSIFICATION OF EXTERNAL CAUSES OF INJURY AND POISONING (E800-E999)**
>
> This section is provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Where a code from this section is applicable, it is intended that it shall be used in addition to a code from one of the main chapters of ICD-9-CM indicating the nature of the condition. Certain other conditions which may be stated to be due to external causes are classified in chapters 1 through 16 of ICD-9-CM. For these, the 'E' code classification should be used as an additional code for more detailed analysis."

At page 980, begins the section that basically deals with malpractice. The section has the rather quaint name of "***MISADVENTURES* TO PATIENTS DURING SURGICAL AND MEDICAL CARE (E7870-E876).**" There are three different codes that could be used to describe what happened to Mr. Hyatt when his only functioning kidney was mistakenly removed. These are E876.5 "Performance of Inappropriate

Operation"; E876.8 "Other Specified Misadventures During Medical Care, Performance of Inappropriate Treatment NEC"; and E876.9 "Unspecified Misadventure During Medical Care." The current edition contains the same three codes.

By failing to include all of the codes that applied, Scott & White Hospital submitted a false claim under the regulations and prevented the peer review organization from reviewing the validity of the coding.

In *Thompson v. Columbia-HCA Healthcare Corporation*, 125 F.3rd 899 (5th Cir. 1997) the Court stated that:

"Thus where the government has conditioned payment of a claim upon a claimants certification of compliance with, for example, a statute or regulation, a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation."

125 F.3rd at 902. The Physician Attestation required by 42 C.F.R. § 412.46 is:

> "I certify that the narrative descriptions of the principal and secondary diagnoses in the major procedures performed are accurate and complete to the best of my knowledge."

Did the Hospital Submit Claims That It Knew Medicare Should Not Pay?

The Medicare Secondary Payer Act, 42 U.S.C. § 1395y provides that Medicare should not be the primary payer when it can reasonably be expected that insurance should pay for the

treatment. Scott & White Hospital was self-insured up to $1 million. It was stipulated that their employee had committed negligence and shortly after that negligence they were informed by Plaintiff that a claim would be pursued. Despite this, they continued to bill Medicare.

This is an area that has not been dealt with definitively by any court, but which is of immense importance to the financial viability of Medicare. If there are tens of thousands of deaths attributable to medical negligence and hundreds of thousands of injuries requiring extra care and lengthened hospital stays, then the drain on Medicare is enormous. In many, or even most of these situations, Medicare should not be the primary payer. By billing Medicare in this case, Scott & White Hospital knew that it was seeking payment in violation of the Medicare Secondary Payer Act. This Court should decide whether that was a false claim under the False Claims Act.

CONCLUSION

A clear conflict exists among various Courts of Appeal concerning when jurisdiction is proper or improper under the False Claims Act. In addition to the cases cited in this petition, there are others that arguably line up on one side or the other. An enormous amount of time and money is being wasted and in the states comprising the Fourth Circuit and the Fifth Circuit the aim of the False Claims Act is being thwarted because of unreasonably strict interpretations of the statute's jurisdictional requirements.

The implications of medical error that is largely preventable has a tremendous impact upon Medicare, the United States Treasury and life itself. In the December 21, 1994 issue of the Journal of the American Medical Association beginning

at page 1851, Dr. Lucien Leape, who is one of the leading experts on medical error in this country, indicated that perhaps 180,000 die each year as a result of largely preventable errors in hospitals. Dr. Leape cites studies indicating an average of 1.7 errors per day per patient. Of those errors, 29% had the potential for serious or fatal injury. Most of these errors will not be discovered by the patient and many will not involve enough money or injury to be pursued by a lawyer so that Medicare can be reimbursed under the Secondary Recovery Act. Unless hospitals include in their diagnostic coding, as required by regulation, the fact that treatment is required because of "misadventures within the hospital," the peer review organizations that look at hospital's medical records will be unable to determine whether Medicare is paying for the hospital's negligence.

Respectfully submitted,

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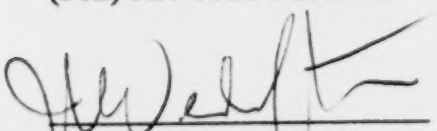

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 99-50031 [FILED
Summary Calendar NOV 08, 1999]

UNITED STATES OF AMERICA, ex rel., RON WEDDINGTON,

Plaintiff-Appellant

vs.

SCOTT & WHITE MEMORIAL HOSPITAL; SCOTT & WHITE CLINIC; SCOTT, SHERWOOD AND BRINDLEY FOUNDATION,

Defendants-Appellees.

Appeal from the United States District Court
For the Western District of Texas

Before KING, Chief Judge, and REYNALDO G. GARZA and EMILIO M. GARZA, Circuit Judges.

PER CURIAM:*

Affirmed. See 5th Cir. R. 47.6.

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* Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
WACO DIVISION

UNITED STATES OF	§	
AMERICA *EX REL.*	§	
RON WEDDINGTON	§	
Plaintiff,	§	
	§	
v.	§	**NO. W-97-CA-208**
	§	
SCOTT AND WHITE	§	
MEMORIAL HOSPITAL;	§	
SCOTT AND WHITE	§	
CLINIC; AND SCOTT,	§	
SHERWOOD AND	§	
BRINDLEY FOUNDATION,	§	
Defendants.	§	

ORDER

On this the day the Court considered this case pursuant to non-jury trial proceedings held before this Court on December 2, 1998. After carefully considering the arguments and authorities presented to this Court in both oral argument and in the parties' briefs, the Court finds that this case should be **DISMISSED** for lack of subject matter jurisdiction.

I. BACKGROUND

This case is a *qui tam* action brought by Ron Weddington ("Weddington"), Relator before the Court pursuant to the Federal False Claims Act ("FCA"). 31 U.S.C. § 3729 *et seq.* The facts giving rise to this case stem from the removal of

a kidney from Charles Hyatt ("Hyatt") in July 1991. Prior to Mr. Hyatt's surgery a surgical nurse placed Mr. Hyatt's angiograms in the view box backward thereby reversing left and right. At the time of surgery Mr. Hyatt's right kidney was not functioning. Along with a renal bypass and other procedures performed during surgery, the doctor, an employee of Scott and White Clinic, mistakenly removed Mr. Hyatt's normal left kidney due to the reversed angiograms. Following the nephrectomy, Mr. Hyatt lost kidney function and was required to undergo dialysis and other medical treatments to live. Mr. Hyatt was a patient of Scott and White Memorial Hospital and Scott and White Clinic until his death approximately six months after his functioning left kidney was removed.

Following the operation, Mr. Hyatt retained Ron Weddington to represent Hyatt against Scott and White. After Hyatt's death Weddington represented Hyatt's estate and his family. Scott and White entered into settlement negotiations with Weddington. During the course of the negotiations Weddington became aware of the existence of a Medicare lien. The amount of the Medicare lien was $64,879.63, the cost of Hyatt's treatment after surgery. A settlement was successfully negotiated by the parties whereby Hyatt's estate and family accepted $3.25 million for their claims against Scott and White. The Medicare lien was to be satisfied out of the proceeds of the settlement.

The purpose of the Medicare lien was to recover payments made to Scott and White for the treatment necessitated by the removal of Hyatt's left kidney. The claims presented to Medicare by Scott and White related only to the medical treatment following Hyatt's nephrectomy, not the procedure itself. Attestations were made to Medicare by Scott and White physicians containing certain codes describing what

treatment or procedures the Medicare funds were to cover. These physician attestations used codes to describe the treatment provided to the patient. The codes used to describe mistakes or accidents during surgery are referred to as "E" codes. The attestations sent to Medicare relating to Hyatt's subsequent treatment did not employ the "E" codes. According to Scott and White, such practice is routine and lawful because Medicare was not billed for the actual surgery, just the medical treatment following the surgery, therefore the "E" codes did not apply. Weddington argues that Scott and White's failure to use the "E" codes amounted to a false claim and provides a cause of action under the FCA.

II. DISCUSSION

The Federal False Claims Act authorizes private persons to bring claims on behalf of the United States Government. 31 U.S.C. § 3730(b). Such an action is described as a *qui tam* action. To prevent abuse of the *qui tam* provision of the FCA, Congress expressly limits the district courts' ability to hear *qui tam* actions brought under § 3730(b). *United States ex rel. S. Prawer and Company v. Fleet Bank of Maine*, 24 F .3d 320, 326 (1st Cir. 1994). These jurisdictional bars prevent the Court from adjudicating certain types of *qui tam* suits. See 31 U.S.C. § 3730(e). More specifically, 3730(e)(4)(A) provides:

> No court shall have jurisdiction over an action under this section based upon the *public disclosure* of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the

person bringing the action is an *original source* of the information. (emphasis added).

Before this Court can reach the merits of Weddington's argument, it must first decide if Weddington's claim is barred by the jurisdictional provisions of 3730(e)(4)(A). The Fifth Circuit has held that in analyzing the jurisdictional question the Court should ask 1) whether there has been a "public disclosure" of the allegations or transactions, 2) whether the *qui tam* action is "based upon" such publicly disclosed allegations, and 3) if so, whether the relator is the "original source" of the information. *Federal Recovery Services, Inc. v. United States*, 72 F.3d 447, 450 (5th Cir. 1995) citing *Cooper v. Blue Cross & Blue Shield of Florida, Inc.*, 19 F.3d 562,565 n. 4 (11th Cir. 1994). Any doubts concerning whether federal jurisdiction is proper are to be resolved against finding federal jurisdiction. See *United States ex rel. Precision Co. v. Koch Industries, Inc.*, 971 F.2d 548, 552 (10th Cir. 1992).

As to the first question, the existence of the Medicare lien was disclosed in a friendly suit filed in the 147th District Court of Travis County. This friendly suit was a result of the events described *supra* involving the removal of Charles Hyatt's kidney. The suit concluded with a court-approved settlement and judgment. At the final hearing on October 2, 1992, the judge gave his approval to the resolution of the suit then stated, "In addition, there will be a Medicare lien of $64,879.63 paid." Joint Exhibit G, p. 22. "*Any* information disclosed through civil litigation and on file with the clerk's office should be considered a public disclosure of allegations in a civil hearing for the purposes of section 3730(e)(4)(A)." *Federal Recovery Systems, Inc.*, 72 F.3d at 450 quoting *United States ex rel. Siller v. Becton Dickinson & Co.*, 21 F.3d 1339,1350 (4th Cir. 1994) (emphasis added). Litigation disclosures include information

obtained during discovery though never filed in court. *United States ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Prudential Insurance Co.*, 944 F.2d 1149,1158 (3rd Cir. 1991). Although the court proceedings here were the result of a friendly suit where no discovery occurred, the Court finds the settlement negotiations here to be sufficiently analogous to discovery for the purpose of the public disclosure analysis. Weddington argues that the disclosure of the Medicare lien in the settlement hearing does not satisfy the public disclosure test. He cites no authority to support this position and a survey of the case law reveals little guidance on this question. As a result, this Court is informed by the Fifth Circuit's opinion in the *Federal Recovery Systems* case. As cited *supra*, the Fifth Circuit in *Federal Recovery Systems* expressly held that *any* information disclosed satisfies the public disclosure test for the purposes of section 3730(e)(4)(A).

Next, the Court must determine whether Weddington's *qui tam* action is based on this public disclosure. Clearly, Weddington discovered the Medicare lien through his representation of Hyatt's estate and family against Scott & White. That representation concluded with the friendly suit filed in Travis County where the lien was made public. While the Medicare lien itself is not the subject of this action, it no doubt prompted Weddington to call Blue Cross and Blue Shield to inquire about Medicare's payments to Scott and White. Plaintiff/Relator Brief on the Merits at 8. "An FCA *qui tam* action even partly based upon publicly disclosed allegations or transactions is nonetheless 'based upon' such allegations or transactions." *Federal Recovery Systems*, 72 F.3d at 451 quoting *United States ex rel.Precision Co.*, 971 F.2d at 552 (emphasis added). Further, Weddington makes no showing that this action is based on anything other than his knowledge of the lien through his representation of the Hyatts. Again, given the

novel issues presented here the Court is guided by the Fifth Circuit's language in *Federal Recovery Systems*. Therefore, the Court finds that Weddington's claim is "based upon" the public disclosure.

Finally, Weddington can still survive the jurisdictional bars if he was the original source of the information. The False Claims Act defines "original source" as "an individual who has direct and independent knowledge of the information on which the allegations are based . . ." 31 U.S.C. §3730(e)(4)(B). "In order to be 'direct' the information must be first-hand knowledge." *United States ex rel. Findley v. FPC-Boron Employees Club*, 105 F.3d 675,690 (D.C. Cir. 1997); See also *United States ex rel. Garibaldi v. Orleans Parish School Board*, 1998 WL 661476 at 8 (E.D. La.); *Wercinski v. International Business Machines Corporation*, 982 F. Supp. 449, 461 (S.D. Tex. 1997). Weddington, by his own admission, obtained the information in this case by calling Blue Cross and Blue Shield who in turn responded to Weddington's request for information. Obviously, Weddington was not privy to Scott and White's preparation of the physician attestations to Medicare.[1] At best, Weddington can only be a secondary source of the information. Therefore, the Court finds that Weddington was not the "original source" of the allegations giving rise to this action. Accordingly, it is

ORDERED that this case is **DISMISSED** for lack of jurisdiction over the subject matter.

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1 It should be noted that the Court makes no finding as to whether Scott and White's billing practices in this case constitute a false claim or were in fact fraudulent.

SIGNED this 11th day of December 1998.

WALTER S. SMITH, JR.
UNITED STATES DISTRICT JUDGE